PATIENT REGISTRATION AND MEDICAL HISTORY

Patient____SS#__________________________________
Last Name First Name M.I.

Street Address____City_____________________State______Zip________

HOME PHONE #_____________________ **WORK PHONE#**______________________ **CELL PHONE#**__________________________

EMAIL ADDRESS___________________________________ **PREFERRED METHOD OF CONFIRMATION**_________________________

Sex: ___**M** ___**F** Age______ Birthdate_________ Single____ Married____ Widowed____ Separated____ Divorced____

PARENT, Guardian (**ONLY IF MINOR)** or **SPOUSE** Name (circle one) ____SS#____________________

Employed By_____________________________________Occupation_________________________Date of Birth____________________

Insurance Policy Holders Full Name ____ Date of Birth__________ SS#_______________

Name of Dental Insurance Company____ Employer __________________________________

In case of emergency, who should be notified?____Ph#__________________________

How did you hear about our office?____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK THOSE THAT APPLY)

___Mitral Valve Pro-lapse
___Heart Problems
___Heart Murmur
___Rheumatic Fever
___Blood Thinners
___High Blood Pressure
___Low Blood Pressure
___Circulatory Problems
___Nervous Problems
___Radiation Treatment/Chemo
___Surgery for any reason

___Diabetes
___General Allergies
___Respiratory Disease
___Epilepsy
___Headaches
___ Hepatitis **A**, **B** or **C** (circle one)
___Immunosuppressive Disorders
___Psychiatric Care
___Jaundice or Liver Disease
___ Chemical Dependency
___Adverse reaction to Dental Treatment

___Arthritis
___Excessive Bleeding
___Hemophilia
___Sinus Problems
___Asthma
___Cancer
___Stroke
___Ulcer
___ Venereal Disease
___ A.I.D.S. or HIV
___**Artificial Heart Valves, Joints, Metal Pins, Screws, etc…**

Please list all prescription Medications you are taking.

1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________
7. ________________________
8. ________________________
9. ________________________

PLEASE LIST SURGERIES____
____

ARE YOU ON OR EVER BEEN ON ANY OSTEOPOROSIS MEDICINE? YES OR NO (CIRCLE ONE)
Name of previous medication_________________ **How long on medicine**_____________

ALLERGIES: DO YOU HAVE ANY ALLEGIES TO ANY MEDICATIONS, LATEX OR ANESTHETICS? YES_______ NO________

IF YES- PLEASE LIST: ____
____

Physician's Name____Phone#______________________Date of Last Physical_____________

Are you under the care of a physician? _____Yes _____No If YES, for what condition______________________________
____

(Women) Are you pregnant? _____ Yes ____No Are you nursing? ____Yes ____No
Do you take birth control of any kind? ____Yes ____No

The above information is current, accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold the dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE_________________________ **PATIENT/GUARDIAN SIGNATURE**____